

Instructions for the Completion of the Plan of Care Summary Form (DMAS-438)

For initial authorizations, the Plan of Care Summary must accompany the Social Assessment and ISARs. The Plan of Care Summary must also be updated and submitted to DMHMRSAS at the annual review.

Check the box beside the type of Waiver.

1. *Identifying information*

- **Individual's Name:** in the appropriate boxes enter last name, first name and middle initial
- **CSP Start Date:** enter the start date (month-day-year) of the Case Manager's plan for this year. This may be earlier than the actual start date of **Waiver** services, but must be used to determine the quarterly review dates and annual reassessment date for the individual's CSP. All Waiver services that begin during the CSP year will follow this review/assessment cycle.
- **Medicaid Number:** enter the consumer's **12 digit** number
- **Date of Last Medical Exam:** Enter the date the individual last had a comprehensive physical exam, in the order "month-day-year." A medical exam must be completed no earlier than one year prior to the actual start of Waiver services. The individual may be approved for enrollment without a current medical, but actual services will not be authorized if it has been more than one year since a physical exam was conducted.
- **CSP End Date:** enter the end date (month-day-year) for the CSP (no more than 365 days [366 in leap years] from the CSP start date). This should be the annual end date of the case management plan.
- **CSB:** enter the name of the CSB/BHA providing (or contracting for) case management services
- **Case Manager:** enter the name of the individual's case manager
- **Phone:** enter the phone number of the individual's case manager, including the area code.

NOTE: The individual name and Medicaid number must be entered on the top of page 2 as well.

2. *Primary goals of the individual*

Enter the goals set by the individual and his/her support team for this CSP year. These are **not** the objectives stated in Individual Service Plans, but the individual's desired

long-term outcomes, which are to be accomplished through the completion of all ISP objectives.

3. *Living Arrangements*

Check what the individual's living situation will be while receiving Waiver services. Please be careful with the response. Critical pre-authorization decisions will be made based on this information.

4. *ICF/MR Level of Functioning*

- Enter the most recent date of completion of the LOF. It must be completed no earlier than 6 months prior to the start of Waiver services and annually thereafter.
- Check the LOF categories met by the consumer. The consumer must meet at least 2 in order to qualify and remain eligible for Waiver services.

5. *Case Management Social Assessment*

- Enter the date that the DMHMRSAS-approved Social Assessment was completed for the individual.

6. *Supports Intensity Scale*

- If the Supports Intensity Scale was completed, enter the Support Needs Index.

7. *Range of services/supports that this individual receives or will receive*

- For each service requested by the individual and family for Waiver funding, as well as each regularly provided or other necessary non-Waiver service or support received by the individual through other funding mechanisms, enter the **provider name**, **amount/frequency** to be provided and requested **start date** on the appropriate line. For Residential and Personal Assistance, also enter the amount of Periodic Support hours (if any) allotted per week.

NOTE: Most Waiver services include an extra line in the event of two providers of the same service. In the unusual event of more than 2 providers (or two providers of a service that does not include an extra line), attach additional pages.

8. *Signatures*

- The case manager must sign and date the form. The individual or guardian must sign and date the form. If the individual has an authorized representative, that person should sign the form. The individual/guardian/authorized representative should receive a copy of the form.